TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PRECINCT AMBULATORY SURGERY CENTER

Respondent Name
TPCIGA FOR ATLANTIC MUTUAL INS

MFDR Tracking Number
M4-18-0066-01

Carrier's Austin Representative
Box Number 50

MFDR Date Received
SEPTEMBER 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was paid incorrectly per Texas Department of Insurance Worker's Compensation claims for Ambulatory Surgery Center Fees are to be paid at 235% of Medicare Fee Schedule for Texas Locality which is Dallas…equals $26731.98"

Amount in Dispute: $9,275.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ASC procedure 63685 has a status indicator of J8 which represents a Device Intensive Procedure. The formula for calculating a Device Intensive Procedure is different from the formula for Non-Device Intensive Procedures. Below is the calculation used during our review which resulted in a total payment of $17,456.90."

Responses Submitted By: TPCIGA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2016	Ambulatory Surgical Care for CPT Code 63685	$9,275.08	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - P12-Workers compensation jurisdictional fee schedule adjustment.
    - Reimbursement based on usual, customary and reasonable for this geographic region.
    - P5-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the recommended payment for the services in dispute? Is the requestor entitled to additional reimbursement?

Findings

1. According to the explanation of benefits, the respondent paid for CPT code 63685 based upon reason code "P12-Workers compensation jurisdictional fee schedule adjustment."

   The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

2. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   CPT code 63685 is defined as "Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling."

   To determine if the requestor was appropriately reimbursement for code 63685 the division refers to 28 Texas Administrative Code §134.402(f)(2)(B).

   28 Texas Administrative Code §134.402(f)(2)(B)(i) and (ii) states, "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply: (2) Reimbursement for device intensive procedures shall be: (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the ASC service portion multiplied by 235 percent."

   A. To determine the MAR for codes 63685 is a five-step process:

   Step 1-Gather factors:

   - According to Addendum B found on CMS website, the hospital outpatient prospective payment amount for code 63685 is $26,728.39.
   - The device dependent APC offset percentage for code 63685 is 86.79%.
   - According to Addendum AA found on CMS website, CPT code 63685 has a Medicare fully implemented ASC reimbursement of $21,258.56.
   - The Core Based Statistical Area (CBSA-City Wage Index) located on the White House/OMB website or CMS website for Hurst, Texas is 0.9526

   Step 2- To determine the device portion, you multiply the hospital outpatient prospective payment amount times the device dependent APC offset percentage:
   $26,728.39 multiplied by 86.79% = $23,197.56.

Step 3 - Find the geographically adjusted Medicare ASC reimbursement for code 63685. This step requires calculations:

- The Medicare fully implemented ASC reimbursement rate of $21,258.56 is divided by 2 = $10,629.28.
- This number multiplied by the City Wage Index for Hurst, TX $10,629.28 X 0.9526 = $10,125.45.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement = $20,754.73.

Step 4- To determine the service portion:

- Subtract the device portion from the geographically adjusted Medicare ASC reimbursement $20,754.73 minus $23,197.56 = -$2,442.83
- Multiply the service portion by the DWC payment adjustment factor of 235%

  $2,442.83 multiplied by 235% = -$5,740.66.

Step 5- To determine the MAR:

- The sum on the service portion and device portion

  $23,197.56 + -$5,740.66 = $17,456.90

Per 28 Texas Administrative Code §134.402(f)(2)(B)(i) and (ii), the MAR is $17,456.90. The respondent paid $17,456.90. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		9/27/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.